

MEDICARE/MEDICAID CRITICAL ACCESS HOSPITAL Accountability and Status Tracking

The purpose of this document is to provide NH Critical Access Hospitals with a complete listing of the conditions and standards based on Appendix W.

This document is based on the Survey Report document that the State of NH Survey and Certification team utilizes at each CAH survey.

KEY:

WHO	Name of person responsible for ensuring this standard is met/complete
DOCUMENTATION	Name of document/policy/manual
LOCATION	Physical place where documentation is stored
STATUS	GREEN: CoP/Standard is met
	YELLOW: CoP/Standard is in process, but not complete
	RED: CoP/Standard is not met and is unlikely to be completed before the anticipated survey dates

If you use initials to designate the WHO, complete the table below to designate initials and full name.

Example:

SJQ	Suzie J Que
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CODE		WHO	DOCUMENTATION	LOCATION	STATUS
C150	<p>§485.608 Condition of Participation: Compliance with Federal, State, and local laws and regulations. The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations</p>				
C151	<p>(a) Standard: Compliance with Federal laws and regulations. The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.</p>				
C152	<p>(b) Standard: Compliance with State and local laws and regulations. All patient care services are furnished in accordance with applicable State and local laws and regulations.</p>				
C153	<p>(c) Standard: Licensure of CAH. The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.</p>				
C154	<p>(d) Standard: Licensure, certification or registration of personnel. Staff of that CAH are licensed, certified, or registered in accordance with applicable State and local laws and regulations.</p>				
C160	<p>§485.610 Condition of Participation: Status and Location</p>				
C161	<p>(a) Standard: Status: The facility is a public or nonprofit hospital.</p>				
C162	<p>(b) Standard: Location. The CAH meets the following requirements-- (1) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under the regulations in §412.62(1) of this chapter.</p>				
C163	<p>(2) The CAH is not deemed to be located in an urban area under §412.63(b) of this chapter.</p>				
C164	<p>(3) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount or by the CMS Medicare Geographic Classification Review Board under §412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under §412.232 of this chapter.</p>				
C165	<p>(4) The CAH is located more than a 35 mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15 mile drive) from a hospital or another CAH, or the CAH is certified by the State as being a necessary provider of health care services to residents in the area.</p>				

CODE		WHO	DOCUMENTATION	LOCATION	STATUS
C170	<p><u>§485.6120 Condition of Participation: Compliance with hospital requirements at time of application.</u></p> <p>The hospital has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for designation as a CAH.</p>				
C191	<p><u>(a) Standard: Agreements with network hospitals.</u></p> <p>In the case of a CAH that is a member of a rural health network as defined in §485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for--</p>				
C192	<p>(1) Patient referral and transfer;</p>				
C193	<p>(2) The development and use of communication systems of the network, including the network's system for the electronic sharing of patient data; and telemetry and medical records, if the network has in operation such a system; and</p>				
C194	<p><u>(b) Standard: Agreement for credentialing and quality assurance.</u></p> <p>Each CAH shall have an agreement with respect to credentialing and quality assurance with at least--</p> <ul style="list-style-type: none"> (i) One hospital that is a member of the network; (ii) One PRO or equivalent entity; or (iii) One other appropriate and qualified entity identified in the State rural health care plan. 				
C200	<p><u>§485.618 Condition of participation: Emergency services.</u></p> <p>The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.</p>				
C201	<p><u>(b) Standard: Availability.</u></p> <p>Emergency services are available on a 24-hour-a-day basis.</p>				
C202	<p><u>(b) Standard: Equipment, supplies, and medications.</u> Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following--</p>				
C203	<p>(1) Drugs and biologicals commonly used in life saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrhythmies, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.</p>				

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C204	(2) Equipment and supplies commonly used in life saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.				
C205	<u>(c) Standard: Blood and blood products.</u> The facility provides, either directly or under arrangements, the following-- (1) Services for the procurement, safekeeping and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours-a-day basis.				
C206	(2) Blood storage facilities that meet the requirements of 42 CFR Part 493, Subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood-banking services are provided under an arrangement, the arrangement is approved by the facility's medical staff and by the persons directly responsible for the operation of the facility.				
C207	<u>(d) Standard: Personnel</u> (1) There must be a practitioner with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on-site within 30 minutes on a 24-hours-a-day-basis.				
C208	(2) The practitioner referred to in paragraph §485.618(d)(1) must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner.				
C209	<u>(c) Standard: Coordination with emergency response systems.</u> The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours-a-day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.				
C210	<u>§485.620 Condition of participation: Number of beds and length of stay.</u>				
C211	(a) Standard: Number of beds. Except as permitted for CAHs having swing-bed agreements under §485.645 of this chapter, the CAH maintains no more than 15 inpatient beds.				
C212	(b) Standard: Length of stay. The CAH discharges or transfers each inpatient within 96 hours after admission, unless a longer period is required because transfer to a hospital is precluded due to inclement weather or other emergency conditions. However, a PRO or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis.				

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C220	§485.623 Condition of participation: Physical plant and environment.				
C221	<u>(a) Standard: Construction.</u> The CAH is constructed, arranged, and maintained to ensure access to and safety of patients and provides adequate space in the provision of direct services.				
C222	<u>(b) Standard: Maintenance.</u> The CAH has housekeeping and preventive maintenance programs to ensure that-- (1) All essential mechanical, electrical, and patient care equipment is maintained in safe operating condition;				
C223	(2) There is proper routine storage and prompt disposal of trash;				
C224	(3) Drugs and biologicals are appropriately stored;				
C225	(4) The premises are clean and orderly; and				
C226	(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.				
C227	<u>(c) Standard: Emergency procedures.</u> The CAH assures the safety of patients in non-medical emergencies by-- (1) Training staff in handling emergencies, including prompt reporting of fires, extinguishing of fires, protection and where necessary, evacuation of patients, personnel, and guests, and cooperation with fire fighting and disaster authorities;				
C228	(2) Providing for an emergency power and lighting in the emergency room and for battery lamps and flashlights in the other areas;				
C229	(3) Providing for and emergency fuel and water supply; and				
C230	(4) Taking other appropriate measures that are consistent with the particular conditions of the area in which the CAH is located.				

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C231	<p><u>(d) Standard: Life safety from fire.</u></p> <p>(1) Except as provided in paragraphs §485.623(d)(2) and (3) of this section, the CAH must meet the requirements of Chapter 12, New Health Care Occupancy, or Chapter 13, Existing Health Care Occupancy, of the 1985 edition of the Life Safety Code of the National Fire Protection Association. Incorporation by reference to the 1985 edition of the National Fire Protection Association's Life Safety code (published February 7, 1985, ANSI/NFPA 101) was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1CFR Part 51. The Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Room C2-07013, Central Building, Baltimore, Maryland 21244-1850 and the Office of the Federal Register, 800 North Capital Street, NW, Suite 700, Washington, D.C. Copies may be obtained from the National Fire Protection Association, Batterymarch Park, Quincy, MA 02209. If any changes in this code are also incorporated by reference, a document to that effect will be published in the Federal Register.</p>				
C232	<p>(2) Any CAH that as a hospital on or before November 26, 1982, complied, with or without waivers, with the requirements of the 1967 edition of the Life Safety Code, or after November 26, 1982, and on or before May 9, 1988, complied with the 1981 edition of the Life Safety Code is considered to be in compliance with this standard as long as the CAH continues to remain in compliance with the edition of the Code. The 1967 and 1981 editions of the Life Safety Code are available for inspection at the CMS Resource Information Center, 7500 Security Boulevard, Room C2-07-13, Central Building, Baltimore, Maryland 21244-1850.</p>				
C233	<p>(3) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigid applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients.</p>				
C234	<p>(4) The CAH maintains written evidence of regular inspection and approval by State and local fire control agencies.</p>				
C240	<p><u>§485.627 Condition of participation: Organizational structure.</u></p>				
C241	<p><u>(a) Standard: Governing body or responsible individual.</u> The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.</p>				

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C242	<p>(b) Standard: Disclosure. The CAH discloses the names and addresses of--</p> <p>(1) Its owners, or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest, in accordance with Subpart C of part 420 of this chapter,</p>				
C243	<p>(2) The person principally responsible for the operation of the CAH; and</p>				
C244	<p>(3) The person responsible for medical direction.</p>				
C250	<p><u>§485.631 Condition of participation: Staffing and staff responsibilities.</u></p>				
C251	<p>(a) Standard: Staffing</p> <p>(1) The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.</p>				
C252	<p>(2) Any ancillary personnel are supervised by the professional staff.</p>				
C253	<p>(3) The staff is sufficient to provide the services essential to the operation of the CAH.</p>				
C254	<p>(4) A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.</p>				
C255	<p>(5) A registered nurse, clinical nursing specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.</p>				
C256	<p>(b) Standard: Responsibilities of the doctor of medicine or osteopathy.</p> <p>(1) The doctor of medicine or osteopathy--</p>				
C257	<p>(i) Provides medical direction for the CAH's health care activities and consultation for the medical supervision of the health care staff;</p>				
C258	<p>(ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH's written policies governing the services it furnishes;</p>				
C259	<p>(iii) In conjunction with the physician assistant and/or nurse practitioner member(s), periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; and</p>				
C260	<p>(iv) Periodically reviews and signs the records of patients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.</p>				

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C261	(2) A doctor of medicine or osteopathy is present for sufficient periods of time, at least once in every two week periods of time, at least once in every two week period (except in extraordinary circumstances) to provide the medical direction, medical care services, consultation, and supervision described in this paragraph, and is available through direct radio or telephone communication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are documented in the records of the CAH. A site visit is not required if no patients have been treated since the last site visit.				
C262	<u>(c) Standard: Physician assistant, nurse practitioner, and clinical nurse specialist responsibilities.</u> (1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH's staff--				
C263	(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and				
C264	(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patient's health records.				
C265	(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy--				
C266	(i) Provides services in accordance with the CAH's policies; and				
C267	(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.				
C268	(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.				
C270	<u>§485.635 Condition of participation: Provision of services.</u>				
C271	<u>(a) Standard: Patient care policies.</u> (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.				
C272	(2) The policies are developed with the advice of a group of professional personnel that includes one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the				

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	provisions of §485.631(a)(1); at least one member is not a member of the CAH staff.				
C273	(3) The policies include the following: (i) A description of the services the CAH furnished directly and those furnished through agreement or arrangement.				
C274	(ii) Policies and procedures for emergency medical services.				
C275	(iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.				
C276	(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.				
C277	(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.				
C278	(vi) A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.				
C279	(vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) is met with respect to inpatients receiving post hospital SNF care.				
C280	(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph §485.635(a)(2) of this section, and reviewed as necessary by the CAH.				
C281	<u>Standard: Direct services.</u> (1) General. The CAH staff furnishes as direct services, those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These direct services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.				

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C282	<p>(2) Laboratory services. The CAH provides, as direct services, basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under Section 353 of the Public Health Service Act (42 U.S.C. 23(a) (See the laboratory requirements specified in Part 493 of this Chapter). The services provided include--</p> <ul style="list-style-type: none"> (i) Chemical examination of urine by dipstick or tablet method or both (including urine ketones). (ii) Hemoglobin or hematocrit; (iii) Blood glucose; (iv) Examination of stool specimens for occult blood; (v) Pregnancy tests; and (vi) Primary culturing for transmittal to a certified laboratory. 				
C283	<p>(3) Radiology services. Radiology services furnished at the CAH are provided as direct services by staff qualified under State law and do not expose CAH patients or staff to radiation hazards.</p>				
C284	<p>(4) Emergency procedures. In accordance with the requirements of §485.618, the CAH provides as direct services, medical emergency procedures as a first response to common life-threatening injuries and acute illness.</p>				
C285	<p><u>(c) Standard: Services provided through agreements or arrangements.</u></p> <p>(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including--</p>				
C286	<p>(i) Inpatient hospital care;</p>				
C287	<p>(ii) Services of doctors of medicine or osteopathy;</p>				
C288	<p>(iii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH; and</p>				
C289	<p>(iv) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.</p>				
C290	<p>(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.</p>				

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C291	(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.				
C292	(4) The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following-- (i) Services furnished whether or not they are furnished under arrangements or agreements;				
C293	(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.				
C294	<u>(d) Standard: Nursing services.</u> Nursing services must meet the needs of patients.				
C295	(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.				
C296	(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.				
C297	(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or physician assistant, where permitted by State law, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.				
C298	(4) A nursing care plan must be developed and kept current for each inpatient.				
C300	<u>§485.638 Condition of participation: Clinical records.</u>				
C301	<u>(a) Standard: Records system.</u> (1) The CAH maintains a clinical records system in accordance with written policies and procedures.				
C302	(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.				
C303	(3) A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.				

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C304	<p>(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable--</p> <p>(i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;</p>				
C305	<p>(ii) Reports of physical examinations, diagnostic and laboratory test results, including laboratory services, and consultative findings;</p>				
C306	<p>(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatments; and</p>				
C307	<p>(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.</p>				
C308	<p>(b) Standard: Protection of record information.</p> <p>(1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.</p>				
C309	<p>(2) Written policies and procedures govern the use and removal of records from the CAH and the condition for the release of information.</p>				
C310	<p>(3) The patient's written consent is required for release of information not required by law.</p>				
C311	<p>(c) Standard: Retention of records. The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.</p>				
C320	<p><u>§485.639 Condition of participation: Surgical services.</u></p> <p>Surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the CAH in accordance with the designation requirements under paragraph (a) of this section.</p>				
C321	<p>(a) Designation of qualified practitioners. The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by-</p> <p>(1) A doctor of medicine or osteopathy, including an osteopathy practitioner recognized under section 1101(a)(7) of the Act;</p> <p>(2) A doctor of dental surgery or dental medicine; or</p>				

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	(3) A doctor of podiatric medicine.				
C322	(b) Anesthetic risk and evaluation. A qualified practitioner, as described in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Before discharge for the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner as described in paragraph (a) of this section.				
C323	(c) Administration of anesthesia. The CAH designates the person who can administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope of practice laws.				
C324	(1) Anesthetics must be administered by-- (i) A qualified anesthesiologist; (ii) A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 110(a)(7) of the Act; (iii) A doctor of dental surgery or dental medicine; (iv) A doctor of podiatric medicine; (v) A certified registered nurse anesthetist, as defined in §410.69(b) of this chapter; or (vi) An anesthesiologist's assistant, as defined in §410.69(b) of this chapter; or (vii) A supervised trainee in an approved educational program, as described in §§413.85 or 413.86 of this chapter.				
C325	(2) In those cases in which a certified registered nurse anesthetist administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner. <u>An anesthesiologist's assistant must be under the supervision of an anesthesiologist.</u>				
C326	<u>(d) Discharge. All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.</u>				
C330	<u>§485.641 Condition of participation: Periodic evaluation and quality assurance review.</u>				
C331	<u>(a) Standard: Periodic evaluation.</u> (1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of --				
C332	(i) The utilization of CAH services, including at least the number of patients served and the volume of services;				
C333	(ii) A representative sample of both active and closed clinical records; and				

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C334	(iii) The CAH's health care policies.				
C335	(2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.				
C336	(b) Standard: Quality assurance. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--				
C337	(1) All patient care services and other services affecting patient health and safety, are evaluated;				
C338	(2) Nosocomial infections and medication therapy are evaluated;				
C339	<i>(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;</i>				
C340	<i>(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by--</i> (i) One hospital that is a member of the network, when applicable; or (ii) One PRO or equivalent entity; or (iii) One other appropriate and qualified entity identified in the State rural health care plan; and				
C341	<i>(5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the PRO, and takes corrective action if necessary.</i>				
C342	<i>(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.</i>				
C343	<i>(iii) The CAH documents the outcome of all remedial action.</i>				
C350	<u>§485.645 Special requirements for CAH providers of long-term care services ("swing-bed").</u> A CAH must meet the following requirements in order to be granted an approval from CMS to provide post-hospital SNF care as specified in §409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph © of this section.				
C351	(a) Eligibility. A CAH must meet the following eligibility requirements-- (1) The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and				

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	<p>(2) The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.</p>				
C352	<p>(b) Facilities participating as rural primary care hospitals (RPCHs) on September 30, 1997. These facilities must meet the following requirements--</p> <p>(1) Notwithstanding paragraph (a) of this section, a CAH that participated in Medicare as a (RPCH) on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions, and limitations that were applicable at the time these approvals were granted.</p> <p>(2) A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and a swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section, and may not request reinstatement under paragraph (b)(1) of this section.</p>				
C355	<p>(c) Payment. Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with §413.70 of this chapter. Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in §413.114 of this chapter.</p>				
C360	<p>SNF services. The CAH is substantially in compliance with the following SNF requirements contained in Subpart B of part 483 of this chapter.</p> <p>(1) Resident rights (§483.10(b)(3) through (b)(6), (e), (h), (i), (j), (l)(vii) and (viii) and (viii), (l), and (m) of this chapter);</p> <p>(2) Admission transfer, and discharge rights (§483.12(a) of this chapter);</p> <p>(3) Resident behavior and facility practices (§483.13 of this chapter);</p> <p>(4) Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §483.15(f)(2), or by the individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy;</p> <p>(5) Social services (§483.15(g) of this chapter);</p> <p>(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (d), and (e) of this chapter);</p> <p>(7) Specialized rehabilitative services (§483.45 of this chapter);</p> <p>(8) Dental services (§483.55 of this chapter);</p>				

CODE		WHO	DOCUMENTATION	LOCATION	STATUS
	(9) Nutrition (§483.25(i) of this chapter).				
C361	<p>483.10 Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following:</p> <p>(b) Notice of rights and services.</p> <p>(3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p>				
C362	(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive.				
C363	<p>(5) The facility must--</p> <p>(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of --</p> <p>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p> <p>(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>				
C364	<p>(d) Free Choice. The resident has the right to-</p> <p>(1) Choose a personal attending physician.</p>				
C365	(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and				
C366	(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.				

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C367	<p>(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality for his or her personal and clinical records.</p> <p>(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;</p> <p>(3) The resident's right to refuse release of personal and clinical records does not apply when--</p> <p>(i) The resident is transferred to another health care institution; or</p> <p>(ii) Record release is required by law.</p>				
C368	<p>(h) Work. The resident has the right to--</p> <p>(1) Refuse to perform services for the facility;</p> <p>(2) Perform services for the facility, if he or she chooses, when--</p> <p>(i) The plan specifies that nature of the services performed and whether the services are voluntary or paid;</p> <p>(ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;</p> <p>(iii) Compensation for paid services is at or above prevailing rates; and</p> <p>(iv) The resident agrees to the work arrange described in the plan of care.</p>				
C369	<p>(i) Mail. The resident has the right to privacy in written communications, including the right to--</p> <p>(1) Send and promptly receive mail that is unopened; and</p> <p>(2) Have access to stationery, postage, and writing implements at the resident's own expense.</p>				
C370	<p>(j) Access and Visitation Rights.</p> <p>(1) The resident has the right and the facility must provide immediate access to any resident by the following--</p> <p>(i) Any representative of the Secretary;</p> <p>(vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>(viii) Subject to reasonable restrictions and the resident's right to deny or withdraw</p>				

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	consent at any time, others who are visiting with the consent of the resident.				
C371	<i>(l) Personal Property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.</i>				
C372	<i>(m) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.</i>				
C373	<p><u>§483.12 Admission, Transfer, and Discharge Rights.</u></p> <p>(a) <u>Transfer and discharge:</u></p> <p>(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.</p>				
C374	<p>(2) <i>Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--</i></p> <p>(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>(ii) The transfer or discharge is appropriate because the resident's needs cannot be met in the facility;</p> <p>(iii) The safety of individuals in the facility is endangered;</p> <p>(iv) The health of individuals in the facility would otherwise be endangered;</p>				
C375	<p>(v) <u>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</u></p> <p>(vi) The facility ceases to operate.</p>				
C376	<p>(3) <u>Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--</u></p> <p>(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and</p> <p>(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p>				

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C377	<p><u>(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--</u></p> <p>(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.</p> <p>(ii) Record the reasons in the resident's clinical record; and</p> <p>(iii) Include in the notice the items described in paragraph (a)(6) of this section.</p>				
C378	<p><u>(5) Timing of the Notice</u></p> <p>(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (A)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice may be made as soon as practicable before transfer or discharge when--</p> <p>(a) The safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;</p> <p>(b) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;</p> <p>(c) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;</p> <p>(d) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (A)(w)(i) of this section; or</p> <p>(e) A resident has not resided in the facility for 30 days.</p>				
C379	<p><u>(6) Contents of the Notice. The written notice specified in paragraph (a)(4) of this section must include the following:</u></p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement that the resident has the right to appeal the action to the State;</p> <p>(v) The name, address and telephone number of the State long term care ombudsman;</p> <p>(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and</p>				

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	(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally ill Individuals Act.				
C380	<u>(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</u>				
C381	<u>§483.13 Resident behavior and facility practices.</u> (a) <u>Restraints.</u> The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.				
C382	(b) <u>Abuse.</u> The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.				
C383	(ii) <u>Not employ individuals who have been--</u> (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law, or				
C384	(B)Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the state survey and certification agency). (3) <u>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</u> (4) <u>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</u>				

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C385	<p>§483.15 Quality of Life. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.</p> <p>(l) <u>Activities.</u></p> <p>(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>(2) The activities program must be directed by a qualified professional who--</p> <p>(i) Is a qualified therapeutic recreation specialist or an activities professional who--</p> <p>(A) Is licensed or registered, if applicable, by the State in which practicing; and</p> <p>(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or</p> <p>(ii) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a patient activities program in a health care setting; or</p> <p>(iii) Is a qualified occupational therapist or occupational therapy assistant; or</p> <p>(iv) Has completed a training course approved by the State.</p>				
C386	<p>(g) <u>Social Services.</u></p> <p>(1) The facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>NOTE: §483.15(g)(2), which requires a full time qualified social worker be employed, is inapplicable to CAHs.</p>				
C388	<p><u>§483.20 Resident assessment.</u> The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.</p> <p>(b) <u>Comprehensive assessment.</u></p> <p>(1) The facility must make a comprehensive assessment of a resident's needs which--</p> <p>(i) Is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State and approved by the Secretary; and</p> <p>(ii) Describes the resident's capability to perform daily life functions and</p>				

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	<p>significant impairments in functional capacity.</p> <p>(2) The comprehensive assessment must include at least the following information--</p> <ul style="list-style-type: none"> (i) Medically defined conditions and prior medical history. (ii) Medical status measurement; (iii) Physical and mental functional status; (iv) Sensory and physical impairments; (v) Nutritional status and requirements; (vi) Special treatments or procedures; (vii) Mental and psychosocial status; (viii) Discharge potential; (ix) Dental condition; (x) Activities potential; (xi) Rehabilitation potential; (xii) Cognitive status; and (Xiii) Drug therapy. 				
C389	<p><u>(4) Frequency. Assessments must be conducted--</u></p> <ul style="list-style-type: none"> (i) No later than 14 days after the date of admission; (ii) For current NF residents not later than October 1, 1991; (iii) For current SNF residents, not later than January 1, 1991; <p>Item (ii) does not apply to CAHs.</p>				
C390	<p>(iv) Promptly after a significant change in the resident's physical or mental condition; and</p>				
C391	<p>(v) In no case less often than once every 12 months.</p>				
C392	<p>(5) Review of Assessments. The nursing facility must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.</p>				
C393	<p>(6) Use. The results of the assessment are used to develop, review, and revise</p>				

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	the resident's comprehensive plan of care, under paragraph (d) of this section.				
C394	(7) Coordination. The facility must coordinate assessments with any State required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.				
C395	<p><u>(d) Comprehensive care plans.</u></p> <p>(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. the care plan must describe the following--</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and</p> <p>(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10 including the right to refuse treatment under §483.10(b)(4).</p>				
C396	<p>(2) A comprehensive care plan must be--</p> <p>(i) Developed within 7 days after the completion of the comprehensive assessment;</p> <p>(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate state in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and</p> <p>(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.</p>				
C397	<p>(3) The services provided or arranged by the facility must--</p> <p>(i) Meet professional standards of quality; and</p>				
C398	<p>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.</p>				
C399	<p>(c) Discharge summary.</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes--</p>				

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	<p>(1) A recapitulation of the resident's stay.</p> <p>(2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and</p> <p>(3) A post discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</p>				
C400	<p>§483.25 Quality of Care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care.</p> <p>(i) Nutrition.</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident--</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p>				
C401	<p>(2) Receives a therapeutic diet when there is a nutritional problem.</p>				
C402	<p>§483.45 Specialized rehabilitative services.</p> <p>(a) Provision of services.</p> <p>If specialized rehabilitative services such as, not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must--</p> <p>(1) Provide the required services; or</p> <p>(2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p>				
C403	<p>(b) Qualifications.</p> <p>Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.</p>				

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C404	§483.55 <u>Dental services</u> . The facility must assist residents in obtaining routine and 24 hour emergency dental care.				
C405	(a) Skilled nursing facilities. A facility-- (A) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; (2) May charge a Medicare resident an additional amount for routine and emergency dental services;				
C406	(3) Must, if necessary, assist the resident-- (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and (4) Promptly refer residents with lost or damaged dentures to a dentist. NOTE: §483.55(b) does not apply to CAHs.				
C407	<u>The facility-</u> (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) from this part, the dental services to meet the needs of each resident; (i) Routine dental services (to the extent covered under the State plan); and (ii) Routine dental services (to the extent covered under the State plan); and (iii) Emergency dental services. <u>The facility-</u> (2) Must, if necessary, assist the resident-- (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and				
C408	<u>(3) Must promptly refer residents with lost or damaged dentures to a dentist.</u>				